Documentation Standards

The Board periodically receives questions related to documentation of nursing care. It is always best to familiarized yourself with what is required by law. The documentation standards are relevant no matter the format utilized to document nursing care. Please note that legible, accurate, timely and complete documentation is paramount to documenting successfully.

The standards are located on the ABN website www.abn.alabama.gov under tab **"Laws'** in the Alabama Administrative Code for Nursing Chapter **610-X-6**, when downloaded, tab down to **Rule 610-X-6-.06 Documentation Standards.** In addition, to the documentation rules noted below, the standards of practice for nursing include following the facility/organizational policies related to documentation.

610-X-6-.06 Documentation Standards
(1) The standards for documentation of nursing care provided to patients by registered nurses and licensed practical nurses are based on principles of documentation regardless of the documentation format.

(2) Documentation of nursing care shall be:
(a) Legible.

(b) Accurate.

(c) Complete. Complete documentation includes reporting and documenting on appropriate records a patient's status, including signs and symptoms, responses, treatments, medications, other nursing care rendered, communication of pertinent information to other health team members, and unusual occurrences involving the patient. A signature of the writer, whether electronic or written, is required in order for the documentation to be considered complete.

(d) Timely.
(i) Charted at the time or after the care, including medications, is provided. Charting prior to care being provided, including medications, violates principles of documentation.
(ii) Documentation of patient care that is not in the sequence of the time the care was provided shall be recorded as a "late entry" including a date and time the late entry was made as well as the date and time the care was provided.

(e) A mistaken entry in the record by a licensed nurse shall be corrected by a method that does not obliterate, white-out, or destroy the entry.

(f) Corrections to a record by a licensed nurse shall have the name or initials of the individual making the correction.